Ageing & Society **26**, 2006, 849–865. © 2006 Cambridge University Press
doi:10.1017/S0144686X06004855 Printed in the United Kingdom

Specialist services for older people: issues of negative and positive ageism

JAN REED*, MARGARET COOK*, GLENDA COOK*, PAMELA INGLIS* and CHARLOTTE CLARKE*

ABSTRACT

This paper reports findings of a study in 2004 of the development of specialist services for older people in the National Health Service (NHS) in England, as recommended in the Department of Health's *National Service Framework for Older People* (NSF-OP). The study was funded by the Department of Health as part of a programme of research to explore the Framework's implementation. Information was collected through a questionnaire survey about the nature of specialist developments at three levels of the NHS: strategic health authorities (SHAs), provider Trusts, and service units. This produced an overview of developments and a frame from which to select detailed case studies. Analysis of the survey data showed that there were variations in the way that the NSF-OP was being interpreted and implemented. In particular, there was inconsistency in the interpretation of the NSF-OP's anti-ageism standard; some concluded that the strategy discouraged services exclusively for older people, others that it encouraged dedicated provision for them. The tension between creating age-blind and age-defined services was played out in the context of existing service structures, which had been shaped over decades by many local and national influences. These conceptual and historical factors need to be taken into account if services are to change, as developments are shaped by 'bottom-up' local processes as well as 'top-down' policy initiatives. In particular, the tension inherent in the NSF-OP between negative and positive ageism, and its varied interpretations at local levels needs to be taken into account when evaluating progress in implementation.

KEY WORDS – older people, specialist services, National Service Frameworks.

Introduction

This paper reports selected findings from a survey of services for older people in England that was carried out in 2004 as part of a government-funded research programme on the implementation of the *National Service*

* Centre for Care of Older People, University of Northumbria, Newcastle upon Tyne, UK.

Framework for Older People (NSF-OP) (Department of Health 2001). The NSF-OP was developed for National Health services in England and Wales, although some of its principles have been applied to the entire United Kingdom, and several reflect international debates. This framework recognised that there were inadequate services for older people to meet their complex needs and proposed corrective actions, including new types of services and practice, such as 'intermediate care' (between primary care and hospital services) and the 'single assessment process' (SAP), to reduce multiple, duplicative and inconsistent assessments by various health and social care professionals. It also stressed the importance of combating ageism, which it conceived as the use of age as a criterion for *excluding* older people from treatments and services. As Davison and Philp (2003) noted, the NSF-OP followed a number of cases in several countries of older people being denied healthcare or treated without dignity because of their age (as exemplified in Bowling 1999; Minichiello, Browne and Kendig 2000). A fundamental argument of the NSF-OP was, therefore, that older people should have access to appropriate services to meet their multiple needs, and that they should not be excluded from any service because of their age. In the same document, however, the principle is put forward that services for older people should be developed because older people have special treatment and care needs, *i.e.* they require different and dedicated services and clinical specialists.

The NSF-OP's advocacy rests on a set of ideas about ageism and the appropriate responses, specifically the exclusion that derives from ageism must be combated by positive means or affirmative action; that is, the development of specialist services to address older people's particular needs. The course of action recommended by the NSF-OP, however, contradicts the precept it upholds, for it requires the use of age as a criterion of eligibility for the new, specialist services. The NSF-OP was one of several new 'national service frameworks' and supplemented many other directives and standards for the delivery of NHS services, not least the *NHS Plan* (Department of Health 2000). Provider organisations and staff have had to incorporate its ideas alongside many other practical constraints and targets. These issues were the background to the study reported in this paper. As part of the NSF-OP, various studies have been commissioned to inform its development and evaluate its impact. The study reported here was commissioned to explore the development of specialist services for older people by canvassing the views of service users, carers and professionals involved in the care of older people. The paper, however, begins by examining the paradoxes raised by the development of specialist services for older people and by providing a fuller description of the aims and implementation strategy of the NSF-OP.

The paradoxes of specialism and ageism

Health and social care in England, as throughout the United Kingdom and elsewhere, has become both more complex and more responsive to individual needs in recent years, and there has been increasing interest both in developing specialist roles and services and in ensuring widespread adherence to 'good practice'. As more detailed knowledge about needs has developed, generic approaches to health-care delivery have seemed inappropriate, and strategies for developing responsive and specific practice have proliferated. The move towards specialist practice is, then, a consequence of increasing knowledge and understanding. This development of specialist services for older people in the UK has taken four forms (Swift 2002). First, there has been a growth of therapeutic services, as health problems and the associated impairments of old age have been shown to respond to interventions. Secondly, there has been increased interest in rehabilitation and acute care for older people. Thirdly, organisational changes have attempted to co-ordinate and consolidate the many specialist services that meet the health-care needs of older people, *e.g.* hospital blood clinics, primary care medication dispensing, and community health-care treatment of leg ulcers. Fourthly, there has been an increased awareness of the importance of prevention.

Swift (2002) argued that all these developments lie behind the growth of specialist medical care for older people, and have stimulated the establishment of multi-disciplinary hospital departments of 'older people's services' designed to provide, from the perspective of a hospital consultant, a total service for older people. Whatever the historical analysis, the current NSF-OP proposals for older people's services have been organised around the notion of a recognisable age group with distinctive needs. This principle, however, contradicts the objections to the use of age to define groups of people and as a criterion of eligibility for health-care or social-care (as in the NSF-OP). The broader objections to ageism are that it uses negative assumptions and stereotypes of older people to support assertions about how they should be treated, which are often discriminatory (Bytheway 1994; Reed, Stanley and Clarke 2004).

As Powell (2001) argued, this has largely meant the ' problematisation' of older age, that is seeing older people as a burden and a problem, particularly from the perspective of professionals and policy makers, who exercise power and control over older people through their decisions about service structures and processes. Tsuchiya, Dolan and Shaw (2003) described three forms of ageism in societal debates about the needs of older people. 'Health maximisation ageism' claims that because older people have little of their life left, then the benefits of health-care interventions

with old people will be less than with young people. 'Productivity ageism' suggests that because older people are less likely than younger adults to be economically productive, then investment in their care has reduced returns. 'Fair-innings ageism' is based on the idea that everyone reaches an age at which they have been able to achieve most of their goals, and that prolonging life beyond this is an unfair intervention. All three forms of ageism have, as their basis, the implicit or explicit acknowledgement that health-care resources are limited, and that the allocation of these resources involves making choices about the priorities of different groups. It is not surprising, therefore, that the prospect of older people being excluded from services on the basis of their age alone has raised concerns. As Sims (2004) noted, such exclusion has a long history and was evident during the 19th century.

Clinical specialties and dedicated services aim to concentrate knowledge, skills and experience, make assessments more effective and make targeted interventions more possible than a broad-brush or generalist approach. This runs the risk that some people will receive care that they do not need, while others will not receive the care that they do need. The process of delivering specialised care, however, rests on the idea that there are categories of patients that can be reliably differentiated. Traditionally, this has been done by diagnoses of medical conditions. If diabetes is diagnosed, for example, then particular dietary changes are prescribed. This process is effective where a clear diagnosis can be established and there is an agreed knowledge base for practice. Outside the realm of medical diagnoses, however, specialisation becomes more problematic. Defining specialities by age (*e.g.* over 65 years old), health problem (*e.g.* tissue viability), or organisational function (*e.g.* discharge planning), may concentrate attention on some issues but neglect others, as a wide range of service users with different needs are included in the specialism. Even in the case of a specialism defined by a medical diagnosis, people using the service may have diverse needs and experiences that the diagnostic term, by itself, does not recognise.

There are, therefore, problematic issues associated with any nosology and demarcation of hospital specialities. While a definite medical diagnosis might be constructed from various clinical signs, for many patients the signs are not clear-cut and clinical judgement is required to make a diagnosis. The term 'malnutrition', for example, may have a clinical definition, but is likely to be applied relative to the norms of the society in which it is observed. Diagnosis and treatment prescriptions may therefore involve socio-psychological as well as biomedical aspects of health; they are then subject to different sorts of markers and measurements.

The National Service Framework for Older People

The NSF-OP set national standards by which to raise the quality of care and to identify key interventions, and developed strategies for their implementation which were supported by £1.4 billion per year of new funds (until 2004). It provided a framework for the development of services and staff, and has become a driver in the delivery of the NHS modernisation agenda. It set out to ensure high-quality treatment, so that older people were treated as individuals deserving of respect and dignity, and sought to ensure that the care needs of older people were adequately resourced, so that they were available and accessible when required. It specifically argues the need for specialist services for older people, as exemplified by the models that it recommends, specifically specialist old-age multidisciplinary teams with the following core members in all 'district general' hospitals: consultants in old-age (geriatric) medicine, specialist nurses or nurse consultants, physiotherapists, occupational therapists, and speech and language therapists (including advanced-practitioners and consultants), dieticians, social workers or care managers, and pharmacists (DoH 2001; 160). This team, the NSF-OP argues, should be based in a specialist unit, and the specialists should have key roles in: setting standards, protocols and guidelines for the care of older people in the general hospital; in clinical governance; and in training programmes for other staff to disseminate good practice (DoH 2001: 59). Services for older people, however, may be delivered in several ways, although the NSF-OP suggests that three organisational models should predominate:

- Age-defined models that provide services for people above a specified age (usually 75 years)
- Integrated models; care is undertaken on acute wards where specialists in old-age medicine work with physicians in integrated teams.
- Needs-based models; patients are allocated wards based on locally agreed criteria, usually based on clinical need (2001: 59).

Although there are models of how specialist services for older people should be configured, the term remains ambiguous and flexible, and the form of services will differ by the context, which allows services to develop appropriately in response to local as well as national needs.

Defining 'specialist' services and staff

While the development of specialist services for older people may be construed as 'positive ageism', the ambiguities surrounding the concept

of specialisation have fostered disparate interpretations, some of which may impede the delivery of effective and responsive care. The practice-development literature suggests that 'specialist' services and staff are distinguished by higher knowledge, skills and experience. There are problems, however, inherent in developing specialist services in organisations with a complex structure and history. For one thing, there are many professions involved in providing specialist services for older people, including nurses, physicians, physiotherapists, and speech and language therapists. They may or may not be specialists in provision for older people, but by the nature of their work, many work almost exclusively with older clients, *e.g.* those who treat cataracts and those who deliver stroke rehabilitation work mainly with older people. Johnson (1998) found that staff in the long-term care sector had considerable practical experience but few qualifications. Not all professional bodies accept that experience in particular services is a sufficient qualification for the appellation 'specialist'. The United Kingdom *Central Council for Nurses and Midwives* (1994), for example, suggested that being a specialist nurse must not be confused with working in a speciality, and that the latter does not guarantee appropriate skills and expertise. There are questions, then, about how specialist services for older people are demarcated, most particularly whether they are best defined by the needs of the service users, by the skills of the staff, or by the chronological age of service users.

Research aims and approach

The purpose of the study was to appraise the progress in England with the development of specialist services and staff for older people. To capture the developments and the working arrangements not only in the NHS but also in local authority social services and among independent not-for-profit and for-profit organisations, a questionnaire survey was undertaken. The respondents were also invited to participate in a more detailed case study of service provision in their locality. Six case-study sites were selected, and all had a focus on the role of specialist nurses for older people. This paper concentrates on the findings about developments in the NHS (the case studies will be reported elsewhere). The study began in April 2003 at a time of considerable change in the NHS and in research governance. Research ethics approval was gained from the Northern Multi-Site Research Ethics Committee. Initially, 357 NHS organisations were approached to establish their suitability for inclusion in the survey, and from the responses it was decided to include 255 organisations.

The negotiations to obtain approval were protracted, but was received from 247 organisations by the cut-off date in July 2004.

Selection of the sample and development of the NHS questionnaires

To obtain information for all levels and aspects of NHS services for older people, a three-stage inquiry was designed, each with a specific semi-structured questionnaire. Each questionnaire was piloted twice, which improved the wording and relevance of the questions. First, 28 regional Strategic Health Authorities (SHAs) were identified and their leads for older people were invited to complete the SHA questionnaire face-to-face or, if more convenient, in a telephone interview. The SHA questionnaire included questions on: the number and type of NHS organisations in the SHA, the communication arrangements between the local NHS organisations and the SHA, the definitions of specialist services for older people, key local and national issues, and contact details for each organisation's Local Implementation Team (LIT) leads for older people's services in the strategic area. Twenty-one interviews were completed.

Secondly, a sample of local organisations (or NHS trusts) was drawn from the comprehensive list on the Department of Health website. It was judged that 509 organisations, including acute trusts, primary-care trusts and care trusts, were relevant to the study (there were exclusions, *e.g.* child-care trusts). The selected trusts were stratified into acute care and primary-care, and 70 per cent of each group were sampled (n = 355). For each of these trusts, the research governance approval process was commenced, and within the time limitations of the study approval for the research to go ahead was granted for 247 trusts (69 %). The LIT leads identified by the SHA leads for older people were contacted and asked to complete a more detailed, organisation questionnaire, but not all NHS organisations had identified LIT leads; for those without, the chief executives were the contacts. A covering letter and an organisation questionnaire was sent to them asking if they would pass the questionnaire to the most appropriate person within their organisation. The main topics of the questionnaire were:

- How specialist services for older people are defined.
- Local and national issues in the development of specialist services for older people.
- An overview of the services available for older people in the organisation.

- How specialist staff are defined.
- Which specialist staff older people access within the organisation, and their roles.
- Contact details of three services that make a significant contribution to the NSF-OP.

Thirdly, 190 services were identified (2.5 per trust) and each contacted to complete a service questionnaire, and 94 (49.5 %) responded. This questionnaire fulfilled two objectives; it gathered data for inclusion into the survey and was used to select services for invitation to participate in the case-study stage of the research. The main topics of the questionnaire were:

- When the service was set up.
- Description of the service, profile of service users, population served and locality.
- Why the service was developed, and intended outcomes.
- Its links with other agencies and departments, and sources of referrals.
- Its priority in the local delivery plans.
- How the service is resourced.
- Ways in which the service gives wider choice to older people.
- The ways in which it promotes the independence of older people.

At each stage of the sampling procedure, attrition occurred for reasons that cannot be established with certainty. Among the possible factors were, first, the research was carried out as NHS SHAs, trusts and services were being established, and this meant that staff and structures were having to deal with organisational and job changes as the study took place. It was therefore difficult to identify the most appropriate recipient for questionnaires. Secondly, the research was commissioned as research governance procedures were being established, and confusions over this process meant that, at some sites, the process was not completed. Thirdly, for a few staff the study was one of many in which they were involved, with resultant pressures on time. It is difficult to estimate the impact of these factors, partly because there have been few comparable studies. A search for questionnaire response rates on both the Department of Health website and an academic literature search engine found no comparable published studies, because most related work has focused on small numbers of staff or on organisations in particular localities, or was carried out before the research governance changes. While these studies may have achieved a higher response rate, their target population was not as broad as in this study. The attrition must however be borne in mind when interpreting the findings.

TABLE 1. *Strategic Health Authorities' definitions of specialist services for older people*

Definition	Frequency	Percentage
Cannot discriminate on age/define by age	14	35·9
Needs-related	8	20.5
Diagnosis	4	10.2
Those which older people use substantially	4	10.2
Access to skilled staff/teams/integrated teams	3	7·7
All services should be for older people	3	7·7
Defined by age/age-related	2	5.1
No comment	1	2.5
Totals	39	100.0

Coding and analysis

The research questions were operationalised by the items in the questionnaire and validated during its design. A coding scheme set out the initial nominal categories, and was also validated by the full research team. The coding of the questionnaires was carried out independently by two members of the research team, and the results compared and differences resolved. During the coding process, these checks were repeated at regular intervals. The findings presented here are primarily descriptive, and focus on the frequencies of various service developments and the respondents' explanations and assessments of these changes. The discussion in this paper focuses on the attitudes towards the development of specialist services and their congruence with combating ageism.

Findings

Definitions of specialist services at the level of strategic health authorities

The responses to the open-ended questions from the Older People's Leads in the SHAs suggested that there was no universal definition of specialist services for older people (one SHA stated that they could not comment on this issue because they believed it was down to each individual organisation to make their own). The remaining 20 responses from SHAs yielded 38 assigned nominal codes and demonstrated much variation of views. They are arranged in order of frequency in Table 1. It is notable that the most frequent response was that defining services on the basis of age was unacceptable. This group included the following individual responses:

> There are still some services which have an age criterion, but there is a move towards condition-specific services (*e.g.* stroke), because of good practice and age discrimination.

[We] don't really define specialist services for older people; more the services are around mental health (they need a specialist service for older people) and intermediate care. It comes under the definition of old people but the service is not around age, it is more diagnostic. So, it's about the needs, not the age. But we need to be moving more about the needs, a person-centred approach.

[We] need a broader approach, in reality there is no uniformity of application or definition. So really it is those which older people use substantially and are classed as older-people's specialist services.

These comments echo the debates about ageism in its negative sense, that is, that the use of age as a defining characteristic can be inherently discriminatory and bring adverse consequences. Several respondents also annotated the questionnaire with supplementary comments that indicated some confusion regarding the NSF-OP and issues of ageism. Some commented that they could not have specialist services dedicated for older people, because this would constitute age discrimination. For example, one respondent explained, '[there are services] predominantly targeted at older people with needs related to their age ... but these services do not exclude anyone with the same needs just because they are not older people ... so [the service] names have to be quite general'. This confusion can again be related to the messages in the NSF-OP that discourage age discrimination (in terms of exclusion from services on the basis of age), and that advocate that each general hospital has a specialist team for older people; in other words, an age-based service. As one SHA respondent commented, 'there are mixed messages in the NSF regarding age discrimination: we must stamp it out, and we must have an older people's team in every hospital'. This paradox features in the NSF-OP, which states that age discrimination is, 'action which adversely affects the older person because of their chronological age alone', and notes that 'discrimination can also mean positive discrimination ... but the term age discrimination is generally used in a negative sense in this NSF' (DoH 2001: 151). The responses from the SHAs suggest that policies on ageism have focused on eliminating negative discrimination – that services should not be delineated as old-age specific.

Definitions of specialist services at the NHS trust level

Seventy-seven contacts in NHS trusts completed the questionnaire, but five offered no comment on their definition of specialist services. The remaining 72 responses yielded 133 nominal codes, which are displayed in order of frequency in Table 2. The most frequent (43.5%) definition of specialist services was 'needs-based', as defined in the NSF-OP. The next most frequent replies were definitions relating to 'age-related'

TABLE 2. *Organisations' and NHS trusts' definitions of specialist services for older people*

Definition	Frequency	Percentage
Attributes of services:		
Needs-based	60	43·5
Age-related services	48	34·8
Integrated services	14	10.2
Prevention services	5	3.6
Work to NSF standards	5	3.6
Response services	1	0.7
No comments	5	3.6
Identification of national issues:		
Resources/competing issues	35	23·5
Multi-professional/agencies issues	26	17.4
Specific service/development (stroke)	23	5·4
Access (ageism/ethnicity/equality/physical)	16	10.7
Staffing issues (retention/recruitment)	14	9·4
National benchmarking/standardisation	9	6.0
Growing older population	5	3·4
Definitions (roles/services)	5	3·4
User involvement	5	3·4
Assessment (single assessment process)	3	2.0
Negative image of nursing services	2	1.3
Environment/area/rurality	1	0.7
No comments	5	3·4
Identification of local issues		
Multi-professional/agencies issues	38	20.1
Resources/competing issues	32	16.9
Specific service/development (stroke)	29	15·3
Staffing issues (retention/recruitment)	27	14·3
Access (ageism/ethnicity/equality/physical)	27	14·3
User involvement	11	5.8
NSF issues	9	4.8
Growing ageing population	6	3.2
Environment/area/rurality	4	2.1
Avoid admission/stay at home	4	2.1
Benchmarking best practice	1	0.5
Single assessment process	1	0.5

services (34.8 %). The other definitions made up 18 per cent of the ways in which specialist services were defined. Given the SHAs' reluctance to define services on the basis of age, it was surprising that at the level of the NHS Trusts, services were often defined on the basis of age, with this being the second most frequent definition among the respondents' answers.

Some of the respondents' annotations elaborated the view that service developments should be focused on need and not age, *e.g.* '[specialist services are] medical services for older people that are needs-related

rather than strictly age-related'. Another respondent reported that the Trust had a 'Directorate of Rehabilitation and Elderly Medicine that is responsible for managing the services most often needed by older people; however, access to those services is determined by referral from GPs and not on an arbitrary age split'. Another trust's response was that: 'specialist services are ... configured to meet the particular and in some cases unique needs of the older person, many of our services are [about] ageing, *i.e.* the services do not exclude younger persons but are needs-based'. Another trust noted their 'provision of a service appropriate to the needs of the patient without prejudice of age'. The argument here was that while there were services that were most used by older people, for example stroke services, they might also be used by younger people, and that services should be based on need, not on age.

There were also comments that all services should be sensitive to the needs of older people, as they were the predominant users of NHS services. One trust responded thus: 'specialist services for older people are defined by a team of professionals who have specialist clinical knowledge that includes older people ... an example being the specialist nutrition nurse: she obviously has detailed knowledge about clinical issues relating to nutrition, but the majority of her work will bring her into contact with older people'. As services become more person-centred, some respondents argued, the need for defining services by age will decrease, and services should therefore become less discriminatory. These comments demonstrated an awareness of service development issues, and the definitions identified in the questionnaire responses reflected the actual and current structure of services.

Local and national issues identified at the level of NHS trusts

From the comments reported thus far, health services in England seem to be in a quandary – there is an ambiguity of definitions and a reluctance to define services on the basis of age, yet it is realised that if they are not specifically identified, there is a danger of older people's needs being under-recognised. This evinces a tension between positive and negative ageism, as services are encouraged to become more aware of and responsive to older people's needs, but must avoid using stereotypes of older people as a basis for exclusion from services. One such response captured the quandary: 'a key issue ... is understanding how a professional's specialism includes the needs of older people'. Another stated the need for a 'competent and skilled workforce to respond to challenges associated with the care of older people [and] resources to meet need [when] competing against other high profile pressures'.

TABLE 3. *The organisations' and NHS trusts' identification of national issues*

National issue	Frequency	Percentage
Resources/competing issues	35	23·5
Multi-professional/agencies issues	26	17·4
Specific service/development (stroke)	23	5·4
Access (ageism/ethnicity/equality/physical)	16	10.7
Staffing issues (retention/recruitment)	14	9·4
National benchmarking/standardisation	9	6.0
Growing ageing population	5	3·4
Definitions (roles/services)	5	3·4
User involvement	5	3·4
Assessment (Single Assessment Process)	3	2.0
Negative image of nursing services	2	1.3
Environment/area/rurality	1	0.7
No comments	5	3·4

The expressed views also suggest tensions between the responses from the different levels of the NHS. Whereas the SHA responses reflected overall policy directions, and specifically a concern to avoid discrimination against older people, the responses from the trusts and services most often reflected organisational and service histories. The changes advocated by the NSF-OP have to be implemented against the framework of existing services, which have mainly developed in response to previous policy initiatives.

When asked to describe the national and local issues for the development of specialist services for older people, five trusts offered no comment regarding the national issues, and the 72 replies yielded 144 nominal codes (Table 3). All 77 trusts made comments regarding local issues and they produced 189 codes (Table 4). As the tables show, the trusts reported that several factors had shaped services for older people. In both tables, resources and multi-professional issues were the two most frequently mentioned issues, followed by the development of stroke services. There were differences, however, notably that recruitment and staffing issues constituted 14.3 per cent of the local issues but only 9.4 per cent of the national issues. One trust's response was that, 'an increasing number of older people plus higher need plus higher expectations equals higher costs [with] insufficient investment in prevention and/or minimisation of the effects of ageing and illness'. Another responded, 'thinking that targets are the answer, the NSF LIT meetings have demonstrated that every organisation is working independently to achieve targets rather than thinking broadly in terms of improving health outcomes for older people by working together'. This point was echoed in the following response, '[the issues are] actively to manage service redesign and

TABLE 4. *The organisations' and NHS trusts' identification of local issues*

Local issue	Frequency	Percentage
Resources/competing issues	35	23.5
Multi-professional/agencies issues:	38	20.1
Resources/competing issues	32	16.9
Specific service development (stroke)	29	15.3
Staffing issues (retention/recruitment)	27	14.3
Access (ageism/ethnicity/equality/physical)	27	14.3
User involvement	11	5.8
National Service Framework issues	9	4.8
Growing ageing population	6	3.2
Environment/area/rurality	4	2.1
Avoid admission/stay at home	4	2.1
Benchmarking best practice	1	0.5
Single Assessment Process	1	0.5

reconfiguration based on the available evidence of best practice, [whilst] ensuring recruitment and retention strategies are in place that will ensure that the right number of staff with the right sets of skills and diversity are available at the right time, [and] that all staff, specialist and generalist, are competent in the key areas of caring for older people'. Given this range of local and national issues or 'service drivers', it is not surprising that there were differences between the normative ideas expressed at the SHA level, about the undesirability of designating services according to age, and the operational reports from the trusts, which suggested a more pragmatic approach to delivery.

Service level responses

All 94 respondents in particular services offered comments on why their service had been developed, and they yielded 219 nominal codes. Inter-agency and multi-disciplinary relationships were again frequently mentioned issues but, interestingly, issues of 'need, user response and choice' were the most prevalent (Table 5). This can be interpreted as evidence that services are more aware or more responsive to service-users' needs, and that this is their most important driver. On the other hand, 12.8 per cent of the respondents' comments referred to the NSF standards, with a higher-rank (third) than in the trusts' responses. It is not necessarily the case, then, that awareness of issues was directly linked to organisational level, for example that SHAs are driven most by policy initiatives, while services respond to patient need. The similarities between the trusts' and service respondents' identification of the key issues, as with resources and multi-disciplinary or collaborative working, may have indicated concerns

TABLE 5. *The reasons given for the development of services*

Why service developed	Frequency	Percentage
Need, user response and choice	49	22.4
Develop inter-agency/disciplinary relationships	31	14.2
NSF Standards or themes	28	12.8
Changes in practice	20	9.1
Needs not met in services	18	8.2
Reduce admission	16	7.3
Support	15	6.8
Increase capacity	12	5.5
Timely discharge	10	4.6
In response to government	9	4.1
Equal access to services	4	1.8
Research project/pilot	4	1.8
Care management	2	0.9
Single Assessment Process	1	0.5

that permeate all levels of the NHS, that is, issues that cut across the development of all services, not just those for older people.

Conclusions

The responses from the three levels of NHS organisations suggest that there is a need for more consideration of the implications of defining needs on the basis of age, as in the NSF-OP. While this approach to service development raises awareness of the complexity and diversity of older people, translating these ideas into practice is complex and introduces difficulties, as service managers attempt to reconcile the ideas of positive discrimination in the NSF-OP with previous and current debates about the ways in which negative ageism can be countered. They are working against a background of pervasive service development and change, which may be more important than specific policy initiatives in determining the shape of services, particularly if the dynamic context is not taken into account.

Developing specialist services for older people therefore raises challenging issues, especially when needs are demarcated by socially-constructed definitions. The category 'older people' is itself a relative term and notoriously difficult to define (Reed, Stanley and Clarke 2004). At which age people are considered 'old' differs across cultures and periods – what was old several hundred years ago may be considered young today, and as life expectancy varies across cultures and societies, what is considered old in one culture or group may not be thought so in

another. The criteria that define 'old age' cannot serve as a shorthand descriptor of needs. Older people vary considerably in their physical, psychological, economic and social states, and this variation makes it difficult to identify what knowledge and skills a specialist practitioner needs. Any attempt to develop an inclusive summary of older people's needs runs the risk of becoming a stereotype, and has the potential to be discriminatory. Stating that older people are physically or mentally frail, for example, may be a reflection of what is known about the general ageing process, but applying it to all older people indiscriminately may reinforce lowered expectations of people on the grounds of age – in effect, ageism.

There is, then, a paradox in identifying older people as a distinct group who would benefit from specialist services, because this approach tends to reinforce social stereotypes and assumptions about the characteristics of older people. This paradox is evident in British government policy about health-care provision for older people, as exemplified in the NSF-OP, which begins with a statement about ending age discrimination, most particularly the practice of denying services to older people solely because of their age. When detailing the situation that older people can be in and the services that some need, however, the document inevitably generalises and comes to broad conclusions, despite frequent caveats. The result is an intrinsic paradox in policy and practice development, which must both respect a general principle and make specific operational proposals. Developing services and practice means thinking through policy principles in complex detail, which makes apparent the anomalies and contradictions. The examples reported by the trust and service managers, such as scarce resources, multi-disciplinary working and user choice, illustrate the complexities of developing care against a background of long-standing policy and management concerns.

The findings reported here tally with the NSF-OP audit of ageism, that there is 'a lack of a common definition or wider understanding of age discrimination' (Department of Health 2002: 1), and confirm that services have grown and developed in response to local and national needs and policies. The *Age Concern England* (2002) policy paper on ageism echoed this criticism of negative ageism, and expressed concern that older people were being excluded from care because of their age, and that their needs, which might be related to their age, were not taken into account. This study's findings suggest that the principles of the NSF-OP will take some time to become fully integrated with service developments. In particular, health-care organisations must be supported in thinking more broadly about the directives of the NSF-OP and its models of positive and negative ageism, and about ways to interpret and operationalise these policies.

References

Age Concern England 2002. *Ageism.* Policy Position Paper, Age Concern England, London.

Bowling, A. 1999. Ageism in cardiology. *British Medical Journal*, **319**, 1353–5.

Bytheway, B. 1994. *Ageism.* Open University Press, Buckingham.

Davison, S. and Philp, I. 2003. Time to deliver with dignity. *British Medical Journal*, **326**, 1300.

Department of Health 2000. *The NHS Plan: A Plan for Investment, A Plan for Reform.* Stationery Office, London.

Department of Health 2001. *The National Service Framework for Older People.* Department of Health, London.

Department of Health 2002. *National Service Framework for Older People: Interim Report on Age Discrimination.* Department of Health, London.

Johnson, M. 1998. Home base: re-formulating the long-term and continuing care of older people. *Nursing Standard*, **12**, 23, 21.

Minichiello, V., Browne, J. and Kendig, H. 2000. Perceptions and consequences of ageism: views of older people. *Ageing & Society*, **20**, 253–78.

Powell, J. L. 2001. Theorizing gerontology: the case of old age, professional power, and social policy in the United Kingdom. *Journal of Aging and Identity*, **6**, 3, 117–35.

Reed, J., Stanley, D. and Clarke, C. 2004. *Health, Well-Being and Older People.* Policy Press, Bristol.

Simms, M. 2004. A theory of age exclusion through closure: 'chronological age' to 'clinical need'. *Journal of Aging Studies*, **18**, 445–65.

Swift, C. G. 2002. The NHS English *National Service Framework for Older People*: opportunities and risks. *Clinical Medicine*, **2**, 2, 139–43.

Tsuchiya, A., Dolan, P. and Shaw, R. 2003. Measuring people's preferences regarding ageism in health: some methodological issues and some fresh evidence. *Social Sciences and Medicine.* **57**, 687–96.

United Kingdom Central Council for Nurses and Midwives (UKCCNM) 1994. *The Future of Professional Practice: The Council's Standards for Education and Practice Following Registration.* UKCC, London.

Accepted 17 January 2006

Address for correspondence:
Jan Reed, Centre for Care of Older People, University of Northumbria, Coach Lane East, Newcastle-upon-Tyne NE46 3DL, UK.

e-mail: jan.reed@unn.ac.uk